RELICENSING STUDY - ADULT FAMILY FOSTER CARE

ND DEPARTMENT OF HUMAN SERVICES
AGING SERVICES
SFN 1031 (Rev. 03-2005)

IDENTIFYING INFORMATION

Applicant 1:	Home Telephone Number:	Work Telephone Number:	
Applicant 2:	Home Telephone Number:	Work Telephone Number:	
Street Address:	City:	State:	Zip Code:

Persons Currently Residing in Household (Not AFFC Residents)

NAME	AGE	RELATIONSHIP TO FAMILY

CONTACTS - List the dates of home visits, collateral contact and persons interviewed.

Applicant:		
Collateral Contacts: (1)	(2)	(3)
(4)	(5)	(6)

THE FOLLOWING COMPLETED FORMS OR REPORTS ARE ATTACHED

Application (SFN 1013)	☐ Yes	☐ No	
Fire Safety - Self Declaration (SFN 800)	☐ Yes	☐ No	
Medical History - Self Declaration (SFN 1017)	☐ Yes	☐ No	
Three References (If Applicable)	☐ Yes	☐ No	☐ N/A
Documentation of Competency (SFN 750)	☐ Yes	☐ No	
Documentation of completing fire safety course	☐ Yes	☐ No	
Proof of Insurance:	☐ Yes	☐ No	☐ N/A
Home	☐ Yes	☐ No	☐ N/A
Auto	☐ Yes	☐ No	☐ N/A
Other Reports:	☐ Yes	☐ No	☐ N/A
Inspection of heating unit	☐ Yes	☐ No	☐ N/A
Water testing	☐ Yes	☐ No	☐ N/A
Pet Vaccinations	☐ Yes	☐ No	☐ N/A
Floor Plan	☐ Yes	☐ No	☐ N/A
Sample Meal Plans	☐ Yes	☐ No	☐ N/A
Preadmission Information/House Rules	☐ Yes	☐ No	
Examples of Service Logs	☐ Yes	☐ No	
Background Check Forms have been forwarded to Aging Services Division	☐ Yes	☐ No	☐ N/A
Request to be a Qualified Service Provider Community Based Services (SFN 980)	☐ Yes	☐ No	☐ N/A

APPLICANT(S):

Length of time licensed?	Number of placements since last licensure?
Have there been any physical changes in the home since you were last licensed? If yes, please explain. (Structural changes require a new floor plan with fire escape routes indicated.)	
Who are your current substitute caregivers?	

OWN CHILDREN IN THE HOME (please use additional paper if needed) ☐ N/A

Name:			
Date of Birth:			
Sex:	☐ Female ☐ Male	☐ Female ☐ Male	☐ Female ☐ Male
Health:			
Education level and functioning:			
Special activities, hobbies and interests:			
Relationship with parents and siblings:			
Any special problems that would affect ability to relate to a resident			
How child feels about having a resident in the family.			
How are feelings expressed by this child.			

How has your family adjusted to you providing Adult Family Foster Care?

Describe your feelings about providing Adult Family Foster Care?

Have there been any major or significant changes in your lives? ☐ Yes ☐ No
Please explain.

Have you become involved with any other agencies through a resident? ☐ Yes ☐ No
Please explain.

Have you struggled with any behaviors with a resident? ☐ Yes ☐ No
Explain the problem and the outcome of the problem.

Please describe any changes in your knowledge/understanding of meeting the needs of your residents?

How has your method of handling stress changed since last licensure? Do you feel you have adequate time for yourself?

Have you become involved in any new agencies, organizations, or groups in your personal life?

Describe your leisure time activities:

Does your household have any pets? ☐ Yes ☐ No Use additional paper if needed.

NAME	TYPE OF PET	INSIDE OR OUTSIDE PET?	VACCINATIONS CURRENT? (Attach Verifications)

Are the pets friendly to others? Please explain.

HOME:	
Free of warped or damaged floors, loose or unsecured floor coverage, loose tiles, broken windows, loose or broken handrails, broken light bulbs and other such hazards that would affect the safety of an adult residing in the home.	☐ Yes ☐ No
Maintained free of offensive odors, vermin and dampness.	☐ Yes ☐ No
Maintained by central heating system at a temperature appropriate to the season and good health.	☐ Yes ☐ No
Equipped with handrails on all stairways.	☐ Yes ☐ No
Good housekeeping practices exist.	☐ Yes ☐ No
Rubbish and garbage stored in washable container.	☐ Yes ☐ No
A telecommunication device located on the main floor and available for use by residents.	☐ Yes ☐ No
Food and cooking utensils stored and protected from dust, leaky pipes or other contamination.	☐ Yes ☐ No
Firearms stored, unloaded in a locked cabinet not readily accessible by a resident.	☐ Yes ☐ No
Served by a fire department.	☐ Yes ☐ No
Emergency numbers posted by phone.	☐ Yes ☐ No
BEDROOM(S):	
Bedrooms at least one window.	☐ Yes ☐ No
Bedrooms constructed as bedrooms.	☐ Yes ☐ No
Beds at least 36 inches wide.	☐ Yes ☐ No
Bedrooms for one person at least 70 square feet.	☐ Yes ☐ No
Bedrooms for two persons at least 120 square feet.	☐ Yes ☐ No
Bedroom has provisions for a resident's personal items.	☐ Yes ☐ No
Bedroom ceilings at least 6'8" high at the lowest point.	☐ Yes ☐ No
BATHROOM(S):	
Toilet and sink facilities on the same floor as bedrooms occupied by residents.	☐ Yes ☐ No
Bathroom for individual privacy.	☐ Yes ☐ No
Bathroom doors can be unlocked from outside.	☐ Yes ☐ No
Bathrooms equipped with safety mats or slip preventing materials on the bottom of tubs and floors of showers.	☐ Yes ☐ No
Bathrooms vented to outside or has outside window.	☐ Yes ☐ No
MISCELLANEOUS:	
Will the provider accept visits with children, relatives and friends of the residents?	☐ Yes ☐ No
The applicant is the spouse of a resident receiving care?	☐ Yes ☐ No
Household pets have been vaccinated?	☐ Yes ☐ No
MOBILE HOME UNITS MUST: ☐ **N/A**	
Have been constructed since 1976.	☐ Yes ☐ No
Have been designed for use as a dwelling rather than as a travel trailer.	☐ Yes ☐ No

THE PROVIDER ASSURES THAT:		
Residents will be provided a copy of the house rules.	☐ Yes	☐ No
No more than two resident will be assigned to a bedroom.	☐ Yes	☐ No
Resident of the opposite sex, unless married, shall not occupy the same bedroom.	☐ Yes	☐ No
The provider, or provider's family, relatives or guests will not sleep in living areas or share a bedroom with a resident.	☐ Yes	☐ No
Each single resident will have a separate bed.	☐ Yes	☐ No
Each bed will have clean bedding that is appropriate to the season.	☐ Yes	☐ No
Residents will be provided with individual towels and wash cloths that are laundered on a regular basis.	☐ Yes	☐ No
Three well balanced meals will be served daily.	☐ Yes	☐ No
Special dietary needs of residents will be addressed.	☐ Yes	☐ No
There will be no more than 14 hours between the conclusion of the evening meal and the serving of breakfast.	☐ Yes	☐ No
The provider has household liability insurance and automobile insurance coverage.	☐ Yes	☐ No
The substitute caregiver is qualified to provide family foster care for adults.	☐ Yes	☐ No
The provider resides continuously in the home.	☐ Yes	☐ No
THE PROVIDER UNDERSTANDS:		
The State/Agency's policies/procedures/guidelines (Reference NDCC Chapter 50-11, NDAC Chapter 75-03-21 & DHS Service Chapter 660-05).	☐ Yes	☐ No
The Agency's responsibility and function.	☐ Yes	☐ No
The Agency's supervision of AFFC.	☐ Yes	☐ No
The reasons for the home study/licensure.	☐ Yes	☐ No
Notification to agency in event of:	☐ Yes	☐ No
Changes in home	☐ Yes	☐ No
Any illness or injury to resident	☐ Yes	☐ No
Inability to keep resident	☐ Yes	☐ No
While providing AFFC, the provider will not accept another resident without consulting with the agency's licensing agent or case manager.	☐ Yes	☐ No
Confidentiality requirements.	☐ Yes	☐ No
Signature of Applicant 1:	Date:	
Signature of Applicant 2:	Date:	

RECOMMENDATION:

☐ Recommended application be denied (attach reasons and conditions)	
☐ Recommend application be approved for a provision license effective on this date:	Number of Adults: ☐ Male ☐ Female ☐ Both
☐ Recommend application be approved for an unrestricted license effective on this date:	Number of Adults: ☐ Male ☐ Female ☐ Both
Signed By:	Date:

HUMAN SERVICE CENTER USE:

The application for a license to provide Adult Family Foster Home Care is: ☐ Approved ☐ Denied	Effective Date:
Signed By:	Date: